Policy
Neighborhood Health Plan reimburses for medically necessary diagnostic and high-technology radiology services.

Policy Definition
- Diagnostic imaging services include diagnostic radiology, mammography, bone densitometry, and ultrasound procedures
- High technology imaging services include magnetic resonance imaging (MRI), magnetic resonance angiography (MRA), computerized tomography (CT), computerized tomographic angiography (CTA), and positron emission tomography (PET)

NHP partners with eviCore for authorization requirements on high technology imaging services, ultrasound services, and cardiac studies. In addition, authorization through eviCore is required for radiation therapy and lab services.

Effective dates for the eviCore partnership and prior authorization process are as follows:
- 8/1/2016 for High Technology Imaging, Non-Obstetrical Ultrasound, Lab Services, Genetic Testing and Cardiac Studies

Provider portals for online prior authorization requests can be found here:

Contact eviCore toll-free at 888-693-3211 between the hours of 8:00am – 9:00pm EST

Prior authorization can be submitted via fax for High Technology Imaging, Ultrasound, and Cardiac studies at 888-693-3210.
Radiation Therapy and Lab requests may not be requested via fax.

Inpatient diagnostic and high technology imaging does not require prior authorization.

Reimbursement
Providers are reimbursed according to the plan’s network provider reimbursement or contracted rates. Claims are subject to payment edits that are updated at regular intervals.
Covered services are defined by the member’s benefit plan. The manner in which covered services are reimbursed is determined by the Neighborhood Health Plan Payment Policy and by the provider’s agreement with NHP. Member liability amounts may include, but are not limited to: copayments; deductible(s); and/or co-insurance; and will be applied dependent upon the member’s benefit plan.

Various services and procedures require referral and/or prior authorization. Referral and prior authorization requirements can be located here.

Please reference procedure codes from the current CPT, HCPCS Level II, and ICD-10-CM manuals, as recommended by the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS), and the American Hospital Association. CMS and the AMA revise HIPAA medical codes on a pre-determined basis, including changes to CPT, HCPCS, and ICD-10 codes and definitions.

Please refer to the CMS or CPT guidelines for requisite modifier usage when reporting services. The absence or presence of a modifier may result in differential claim payment or denial.

NHP reviews claims to determine eligibility for payment. Services considered incidental, mutually exclusive, integral to the primary service rendered, or part of a global allowance, are not eligible for separate reimbursement. Please refer to Coding Provider Payment Guidelines for more information.

All claims are subject to audit services and medical records may be requested from the provider.

Neighborhood Health Plan’s reimbursement is based on line of business. Unless otherwise specified within the medical policies, please follow the guidelines based on membership type.

**Neighborhood Health Plan Reimburses**
- Outpatient diagnostic imaging including the following:
  - Diagnostic radiology;
  - Mammography;
  - Bone densitometry; and
  - Ultrasound procedures
- Outpatient high technology imaging including the following:
  - Magnetic resonance imaging (MRI);
  - Magnetic resonance angiography (MRA);
  - Computerized tomography (CT);
  - Computerized tomographic angiography (CTA); and
  - Positron emission tomography (PET)
- Low osmolar contrast for those services requiring contrast materials

**Neighborhood Health Plan Does Not Reimburse**
- Diagnostic ultrasound exam performed with a corresponding diagnostic ultrasound guidance procedure
- Dual energy x-ray absorptiometry (DXA); body composition study
• Fluoroscopic guidance and localization of needle/catheter tip for spinal injections (diagnostic or therapeutic) when billed with myelography, supervision and interpretation (S&I) codes
• Global radiology services to a physician when performed in a hospital inpatient/outpatient place of service
• Scintimammography
• Separate payment for the low osmolar contrast material billed for the second MRI when two MRI services are performed during the same session
• Experimental or investigational diagnostic or high technology imaging services

Provider Payment Guidelines and Documentation
• Facilities billing both the technical and the professional components of the radiologic service are reimbursed globally according to their contract with NHP
• High osmolar contrast media for CT scans that specify “with contrast” is included in the technical component
• Only one provider will be reimbursed for the interpretation and report for any one specific service provided
• The appropriate CPT/HCPCS procedure code(s) must be submitted with the revenue code on a UB-04

Billing Guidelines
Professional services should submitted on a CMS-1500 or electronically on an 837P
• Claims should be billed with the appropriate CPT/HCPCS code(s)
• Append modifier 26 to indicate professional components that require the use of a modifier
• List the referring provider and NPI number in boxes 17 and 17b of the CMS-1500; refer to your 837P Companion Guide for specific fields
• Claims must be submitted with the appropriate diagnosis code(s)

Technical services should be billed on a UB-04 or electronically on an 837I
• Submit both the revenue code and the CPT/HCPCS code(s)
• Append modifier TC to indicate technical components that require the use of a modifier
• List the ordering provider and NPI number in box 78 on the UB-04; refer to your 837I Companion Guide for specific fields
• Claims must be submitted with the appropriate diagnosis code(s)

Global services can be billed on either a CMS-1500 or a UB-04
• Claims should be billed with the appropriate CPT/HCPCS code(s)
• The ordering provider and NPI number must be listed
• Claims must be submitted with the appropriate diagnosis code(s)

Procedure Codes
Please refer to the following eviCore links for the CPT codes which adhere to the guideline and authorization requirement:

Non-Obstetrical Ultrasound and Cardiac Study Codes

High Tech Radiology Codes
MassHealth Reimbursement

The following procedure codes are deemed not reimbursable by MassHealth. Neighborhood Health Plan aligns its MassHealth plans with MassHealth guidelines. Therefore, for all MassHealth NHP members, no reimbursement will be made to providers for the codes below.

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>43252</td>
<td>Esophagastroduodenoscopy, flexible, transoral; with optical endomicroscopy</td>
<td>Not reimbursable per MassHealth</td>
</tr>
<tr>
<td>43752</td>
<td>Naso- or oro-gastric tube placement, requiring physician's skill and fluoroscopic guidance (includes fluoroscopy, image documentation and report)</td>
<td></td>
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<tr>
<td>74263</td>
<td>Computed tomographic (CT) colonography, screening, including image postprocessing</td>
<td></td>
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<tr>
<td>76140</td>
<td>Consultation on X-ray examination made elsewhere, written report</td>
<td></td>
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<tr>
<td>76390</td>
<td>Magnetic resonance spectroscopy</td>
<td></td>
</tr>
<tr>
<td>76497</td>
<td>Unlisted computed tomography procedure (eg, diagnostic, interventional)</td>
<td></td>
</tr>
<tr>
<td>76498</td>
<td>Unlisted magnetic resonance procedure (eg, diagnostic, interventional)</td>
<td></td>
</tr>
<tr>
<td>95965</td>
<td>Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (eg, epileptic cerebral cortex localization)</td>
<td></td>
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<tr>
<td>95966</td>
<td>Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (eg, sensory, motor, language, or visual cortex localization)</td>
<td></td>
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<tr>
<td>95967</td>
<td>Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, each additional modality (eg, sensory, motor, language, or visual cortex localization) (List separately in addition to code for primary procedure)</td>
<td></td>
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</tbody>
</table>

Multiple Imaging Reduction Procedures

The following procedure codes are subject to the multiple payment reduction when two or more services are performed during the same encounter. The reduction of payment will be applied to the lower allowable radiological service.

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Multiple Procedure Codes</th>
</tr>
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<tbody>
<tr>
<td>CT, CTA, MRI, MRA, US</td>
<td>70336, 70450, 70460, 70470, 70480, 70481, 70482, 70486, 70487, 70488, 70490, 70491, 70492, 70496, 70498, 70540, 70542, 70543, 70544, 70545, 70546, 70547, 70548, 70549, 70551, 70552, 70553, 70554, 70555, 70556, 71250, 71260, 71270, 71275, 71550, 71551, 71552, 71555, 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, 72133, 72141, 72142, 72146, 72148, 72149, 72156, 72157, 72158, 72159, 72191, 72192, 72193, 72194, 72195, 72196, 72197, 72198, 73200, 73201, 73202, 73206, 73218, 73219, 73220, 73221, 73322, 73323, 73325, 73700, 73701, 73702, 73706, 73718, 73719, 73720, 73721, 73722, 73723, 73725, 74150, 74160, 74170, 74174, 74175, 74176, 74177, 74178, 74181, 74182, 74183, 74185, 74261, 74262, 74712, 75557, 75559, 75561, 75563, 75571, 75572, 75573, 75574, 75635, 76604, 76700, 76705, 76770, 76775, 76801, 76802, 76805, 76810, 76811, 76812, 76815,</td>
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References

CMS 2016 Medicare Physician Fee Schedule RVU Table Diagnostic Imaging Indicator
88 CPT Assistant published by the American Medical Association

Publication History

<table>
<thead>
<tr>
<th>Topic: Radiology Services</th>
<th>Owner: Provider Network Management</th>
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<tbody>
<tr>
<td>April 27, 2010</td>
<td>Original documentation</td>
</tr>
<tr>
<td>May 19, 2011</td>
<td>Authorization grid, cost sharing, reimbursement grid, disclaimer updated</td>
</tr>
<tr>
<td>April 23, 2012</td>
<td>Updated 2012 CPT codes, MPFS radiology indicator 88 codes and payment methodology and referral grid</td>
</tr>
<tr>
<td>January 1, 2013</td>
<td>Added 2013 CPT codes and updated authorization grid and removed deleted codes</td>
</tr>
<tr>
<td>June 1, 2016</td>
<td>Removed definitions, added new codes to MPR grid, removed modifiers/cost sharing table, added new reimbursement language, updated guidelines, and added NHP relationship with eviCore and the new authorization process</td>
</tr>
<tr>
<td>February 1, 2017</td>
<td>Added MassHealth Reimbursement table with codes not deemed payable</td>
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</tbody>
</table>

This document is designed for informational purposes only. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization/notification and utilization management guidelines when applicable, adherence to plan policies and procedures, claims editing logic, and provider contractual agreement. In the event of a conflict between this payment guideline and the provider’s agreement, the terms and conditions of the provider’s agreement shall prevail. Neighborhood Health Plan utilizes McKesson’s claims editing software, ClaimCheck, a clinically oriented, automated program that identifies the “appropriate set” of procedures eligible for provider reimbursement by analyzing the current and historical procedure codes billed on a single date of service and/or multiple dates of service, and also audits across dates of service to identify the unbundling of pre and post-operative care. Questions may be directed to Provider Network Management at prweb@nhp.org.